The PREVENTION CONNECTION
NEWSLETTER

The Effects of Trauma on Kids

by Cindy MacKenzie

Data from one long-term study revealed that as many as 80 percent of young adults with histories of abuse met the diagnostic criteria for at least one psychiatric disorder at age 21[1]. —Solverman, Reinherz, & Giaconia (1996)

I have worked in the juvenile corrections field for the past 15 years. When working with kids in the corrections arena, it is a constant challenge to honor the emotional/physical trauma so many of them have experienced while firmly addressing "in your face" behaviors that have been finely honed, often starting at a very young age. We have been aware for many years of the lasting emotional repercussions of trauma. Research is now showing that there are lasting physical impacts as well. Which has greater negative impact—physical hurt or emotional hurt from experiencing trauma? Which needs more attention—the physical trauma or the emotional damage to the heart or brain? Recent research supports the need to pay equal attention to the physical and the emotional impacts of trauma on the heart *and* the brain. We know that exposure to childhood trauma—either through a one-time incident such as the murder of a parent or sibling, or through ongoing victimization or exposure to extreme stressors such as verbal, physical or sexual abuse and/or chronic neglect—can have long-lasting and devastating impacts on emotional health. Post Traumatic Stress Disorder (PTSD) is a common diagnosis for those who have experienced violence, as victim or witness. Another study (Teicher, 2002) reported associations between abuse and neglect and the psychological and emotional conditions of panic disorder, dissociative disorders, attention-deficit/hyperactivity disorder and reactive attachment disorder[1].

While emotional impacts are well known, the long-term physical consequences of exposure to childhood trauma are just beginning to be understood. A report posted on the American Heart Association website states, "Abused, neglected children more likely to have ischemic heart disease as adults." The report references medical data showing a "dose-response relationship" between the amount of exposure to childhood trauma and the subsequent risk of ischemic heart disease. The data also indicated increased risks for diabetes, obesity, hypertension, smoking and drug abuse. Studies done by Perry (2002) and Shore (1997) demonstrated that child abuse and neglect can actually prevent important regions of the brain from developing properly, hindering physical, emotional and mental development. *Long Term Consequences of Child Abuse and Neglect* sited studies by Perry (2001) and Dallam (2001), which noted that the stress of chronic abuse resulted in a "hyperarousal" response by certain areas in the brain, which could result in impaired brain functioning causing hyperactivity, sleep disturbances, and learning and memory disorders. J. Douglas Bremner[2] reported damage to the hippocampus portion of the brain, involved in learning and memory, as a result of exposure to extreme stressors including childhood abuse. The medial prefrontal cortex, the area of the brain responsible for modulating emotional responsiveness and mediating conditioned fear responses, was also found to be negatively impacted by extreme stressors.

Continued on Page 2

Sources:

[1]*Long-Term Consequences of Child Abuse and Neglect*: National Clearinghouse on Cild Abuse and Neglect (http://nccanch.acf.hhs.gov).

[2]Bremner, J. Douglas. M.D. *The Lasting Effect of Psychological Trauma on Memory and the Hippocampus* (www.lawandpsychiatry.com/html/hippocampus.htm).10/05/2004.

Outside the Sandbox

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The Vicki Column

Our original plan for this issue was to address some of the many kids who fall through the cracks in our systems and our communities—kids dealing with issues unique enough to set them apart. In our research—and in the articles submitted—we found trauma to be a common theme. Trauma links some of our most complex social problems—drug and alcohol abuse, school drop-out, child maltreatment, mental illness, extreme poverty, antisocial behavior, violence, teen pregnancy, juvenile delinquency, runaway, homelessness . . . the list goes on. Like a ring of dominoes, each of these issues is a point on the same circle. Tip one and you can be assured that others will follow, then follow in successive rings, from one generation to the next.

Trauma changes the way children view their worlds, forcing them to challenge assumptions about safety and security. They may regress behaviorally and academically, and begin to exhibit a wide range of psychological symptoms. Research now indicates that beyond long-term psychological implications, childhood trauma may have lasting implications for physical health as well. Research reported in *Trauma, PTSD and Health* (Friedman and Schnurr, 1996) reveals that exposure to catastrophic stress is associated with more health complaints, greater service utilization, more medical illness and increased mortality.

This issue starts with a discussion of trauma, and follows with a first person account by a young woman whose life has been shaped by violence and trauma. You'll see trauma's shadow in many—if not most—of the other articles in this issue. It's a shadow with deep implications that come at a cost for every one of us. It's a long shadow, and one that keeps many children and families from an equal playing field, keeps many children out of the sandbox where strong, healthy foundations are built.

We are standing at a crossroads, looking to a new statewide leadership, to leaders who can set the pace for vigilance on behalf of our most vulnerable citizens. We wish them wisdom, strength, courage . . . and the foresight to remember that a stitch in time saves nine.

Vicki

The Effects of Trauma on Kids

Continued from cover

Dysfunction of these areas of the brain has been linked to pathological emotional responses.

I see the effects of trauma on the girls who come to the Riverside Youth Correctional Facility every day. Not long ago, a girl sat in my office and told me that she'd just learned that God makes no mistakes. *"I was glad to hear that because when my mom gets angry, she always tells me I was a mistake,"* she said. This is one small example of the verbal abuse and emotional neglect this girl has endured. To focus exclusively on her criminal behavior and her inability to get along with people without investigating the level of trauma she's experienced and its impact on her life—emotionally and physically—would be doing her an injustice. It would also mean that those of us who are trying to help her would miss providing the continuum of treatment aspects to support her maturing into a confident, responsible, emotionally and physically healthy adult.

Multiply the needs of this one girl by the thousands upon thousands of children who are forced to live with trauma every year and the costs to our society become incalculable. As reported by *Prevent Child Abuse America* (2001), direct costs including expenditures for the child welfare system, judicial, law enforcement, health and mental health systems are estimated at an annual $24 billion. The indirect, long-term costs include juvenile and adult criminal activity, loss of productivity, mental illness, substance abuse and domestic violence—which have been estimated at more than $69 billion per year. Long-lasting physical and emotional impacts of trauma, particularly those experienced by young children, are not fully understood and best-practices treatment approaches are still being developed. The costs—along with the ever-increasing prevalence of violence in our society—make it imperative that gathering trauma histories becomes part of any type of mental/physical health assessment, and that subsequent treatment recognizes the emotional and the physical needs of persons exposed to trauma.

—Cindy McKenzie is the Superintendent of the Riverside Youth Correctional Facility in Boulder.

The Prevention Connection

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Notes From the Edge

How Violence Has Impacted My Life

by Desa Rae, Resident, Riverside Youth Correctional Facility

I lived in a world of darkness and couldn't find my way out . . . the way they would describe it, I was a lost child. —Desa Rae

Violence is a very meaningful word: it can be used in many ways. Every time I hear the word, I remember that it goes way back into my life. I am Desa Rae. I am 14 years old, on parole and in Riverside Youth Correctional Facility. I am the youngest kid in Riverside.

All my life, I have been in and out of homes, detention centers and facilities, in and out of trouble since the age of 8. Violence has taken a major toll in my life. Violence goes way back to when I was maybe 4 years old. I have been abused in many ways. I have seen my Mom get beat time after time. My mother was in an abusive relationship, which put me and my sister in danger also. I remember many things that I would see and I started doing things that he would do. I became abusive to my sister. My first word was "F– – k." Seeing violence, seeing it happen all the time, well I thought it would be ok if I was violent too. I have seen people get raped, murdered and abused various times in front of my own eyes. It made me hurt and turn toward hatred. I was an ungrateful and selfish child in many eyes. I didn't think so.

Living with violence was hard and it has impacted my life in many ways. I remember that every time I would come home from preschool, I would try to go to my room as fast as I could, because there would be a nasty surprise right around the corner. I got a beating every day by my old stepdad. He would shove alcohol down my throat, and then get mad if I didn't drink it . . . he would also get mad if I *did* drink it, so either way I would get beaten. He has put my mother, me and my sister in the hospital at various times. I lived in a world of darkness and couldn't find my way out . . . the way they would describe it, I was a lost child.

When I was 7 or 8, my sister and I were molested for about a year. When I finally told someone about it, I felt dirty, nasty and guilty. That has affected my life in many ways also. Me living with violence also hurt my mom. I was uncontrollable. I didn't care what my mom or anyone said. I became abusive toward my two little sisters. I would hit them just for the heck of it and now they have started to walk in my footsteps. I started doing drugs and drinking more often. I would use them to ease my pain, and they would hide me from reality. I started failing in school, skipping and fighting almost every day.

I am back in Riverside Youth Correctional Facility for my second time. I am on parole until I am 18 years of age. I have been in and out of JDCs (Juvenile Detention Centers), and have been in two of them—in Billings and Great Falls. This is not the way I want to spend the rest of my life. It is hard to be in the system. Parole teases you—you feel you get more freedom, but you don't. Violence is still in my life in many ways and I feel there is no way to escape from it. Please don't let violence take a toll in your life or let it get to *your* children.

Early Childhood Trauma

The brain's development can literally be altered by prolonged, severe or unpredictable stress, including abuse and neglect, during a child's early years. These experiences result in negative impacts on the child's physical, cognitive, emotional and social growth.Chronic stress sensitizes neural pathways and over-develops certain regions of the brain involved in anxiety and fear responses, and often results in the under-development of other neural pathways and other regions of the brain.

Chronic stress or repeated traumas can result in a number of biological reactions. Neurochemical systems are affected, which can cause a cascade of changes in attention, impulse control, sleep and fine motor control. Early experiences of trauma can also interfere with the development of the subcortical and limbic systems.

Source: *In Focus: Understanding the Effects of Maltreatment on Early Brain Development.* National Clearinghouse on Child Abuse and Neglect Information (HHS). 2001. *nccanch.acf.hhs.gov/pubs/focus/earlybrain.cfm#effects*

High Needs Kids

by Leroy Bingham

The Montana Children's Initiative Provider's Association has completed more than a year of work sampling "high-cost" children's mental health cases—for these purposes defined as costing $6,000 per month or more. The study emphasized analysis of children removed from their homes by Child Protective Services. The survey entailed comprehensive interviews of case workers, probation officers, providers, family members and the children themselves. Together, these interviews provided insights into the lives of 24 of an estimated 130 high-cost cases in Montana.

The survey explored family and caretaker behaviors; their patterns were remarkably similar in terms of rates of alcohol and other substance abuse, homelessness, multiple relocations, unemployment, histories of mental health problems and criminal histories. Domestic violence was slightly lower among caretakers than families, but poverty was clearly a factor in both groups. Among the 24 cases reviewed:

— 87.5% of families had histories of family disruption, drug and substance abuse.

— 75% had histories that included mental health issues.

— 70.8% of the families also had a history of domestic violence and caretaker mental health problems.

— Two-thirds of the families studied had histories that included juvenile or adult involvement with the corrections system.

In looking at the interaction of children with the law enforcement and judicial systems, one-third of the youth surveyed had been involved with the state's district youth court. And though they might not have been caught, more than two-thirds of youth surveyed admitted involvement in a variety of illegal behaviors. The most common offense was drug or paraphernalia possession, followed by theft. Other offenses included youth in need of care, sexual intercourse without consent, burglary, assault and being out of control.

The survey asked questions relating to the child's experience in school and with their peers. Almost all (87.5%) had experienced difficulty in peer relationships, and 83 percent were diagnosed with learning disabilities. Additionally, 79 percent exhibited behavior problems and were in special education or self-contained classrooms. Half had been in alternative schools and half were achieving failing grades, though one-third were achieving at average or better levels academically.

American Indians comprise 6.2 percent of Montana's population, but accounted for 41.7 percent of the high-cost cases surveyed. This is an extreme overrepresentation of nearly seven *times* the expected population incidence. Rates of domestic violence, substance abuse and correctional history were all significantly higher in Indian families, as were multiple relocations, poverty and unemployment. Indian children were twice as likely to be on informal probation, to be withdrawn, runaway or truant. They were less likely to commit violent crimes or property destruction. The Indian children in the study were an average of 1.5 years younger than the non-Indian children, but an average of 2.5 grade levels behind the non-Indian students. American Indian youth appeared to draw strength from their spirituality at a rate of twice that of non-Indian youth, but lagged severely behind in terms of family support and extended support networks.

The study found that American Indian children experience their first out-of-home placements at an earlier age (5 years old) than non-Indian children. This first placement seems to be with the extended family rather than CPS. The average non-Indian child enters the CPS system at age 6, while Indian children arrive in that system at age 7.5, after apparent failure of the first placement with the extended family.

The survey found that 15 of the 24 youth (62.5%) surveyed were placed with providers outside Montana—seven in Texas, four in Utah, two in Wyoming and one each in Washington and Georgia. Of the nine youth who were in treatment in Montana, four were in Helena, three were in Butte and two were in Billings.

The second phase of the study has just been funded by the Child Services Division and should be completed by the end of December.

KIDSfm

$9.5 Million Grant for Children's System of Care

In October 2004, Health & Human Services Secretary Tommy G. Thompson announced the award of four cooperative agreements for use in developing comprehensive community-based mental health services for children and adolescents with serious emotional disturbances and their families. Montana received one of the four grants awarded nationwide. KIDS fm ((Kids Integrated Delivery System For Montana) will provide a statewide system of care in the children's mental health system.

The Children's Mental Health Services Bureau applied for the grant in partnership with the Crow Nation. "This is a great honor for Montana," Pete Surdock, Jr., Bureau Chief of the CMHB stated. "This grant will assist the Bureau in its efforts to enhance and expand the community-based system of care."

The 6-year project will enhance access to an integrated, wraparound system of services that can responsively meet the needs of children and families. Over the 6-year grant period, approximately $5.75 million will be provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) with $3.75 million in match by the state.

The CMHB is part of the Health Resources Division of the Department of Public Health and Human Services. Stay tuned. There will be more about this exciting project in upcoming issues!

The "average" youth in the study had his first out-of-home placement at age 7, and he was 15.85 years old. After an average of almost 9 years in the system, the youth had experienced an average of 7.89 out-of-home placements, and had been in 16 out-of-home placements.

A Loss of Culture

by Lynda Beaudry, NCAC-1, CDS-III, Adolescent Coordinator, Blackfeet Adolescent Treatment Program

One of the worst risks to the children and youth we see is extreme poverty.
—Lynda Beaudry

The Blackfeet Adolescent Treatment Program in Browning administers alcohol/drug assessments to approximately 150 adolescents annually. Based on the assessment results, approximately 40-45 adolescents will enter a primary residential treatment facility. Youth served are predominantly enrolled members of the Blackfeet Tribe, or are of Blackfeet descent. We have however, met the needs of some adolescents who are tribal members of other federally recognized tribes but residing on the Blackfeet Reservation. The most common addictions we're seeing are alcohol and marijuana, but meth is also beginning to raise its ugly head.

One of the major issues these young people are dealing with is the loss of their culture and family values. We are also still seeing the terrible repercussions of the Relocation Act. Many people left the reservations and ultimately found themselves in the inner cities of Chicago, San Francisco, Los Angeles or Dallas. They went wherever they were sent and learned trades, hoping for a better way of life. In the process, their culture was sometimes lost. This has resulted in high divorce rates, terrible poverty and many dysfunctional family situations. With the loss of culture, many kids have also lost a sense of respect for themselves and others. Respect was a value taught to our children long ago, but today, many of our children are basically raising themselves, or are being raised by grandparents or other family members.

The effects of our loss of culture are the primary influences I see when doing assessments on the reservation. These young people don't have to follow traditional ways, but they *are* Native American kids who need to be proud of who they are, where they're coming from and what their culture means. Kids are naturally group oriented and will jump at anything that seems "cool" because they have to find a way to fit in. Lately, many are trying to copy Black or Hispanic styles, even picking up their slang. They are searching for an identity and in the process, many just get lost.

We work hard to look at each youth and try to meet his or her needs on an individual basis. Sometimes sending them out to treatment facilities that enhance their cultural identity works. We often send them to the nearest residential facility, like Rocky Mountain Treatment Center in Great Falls to accommodate the needs of family members who wish to participate in the adolescent's treatment. Others have done very well at the Montana Youth Challenge Boot camp in Dillon. Success—what works—is highly individual, but the success stories are the ones we never forget.

One young man who had alcohol/drug problems was sent to the one of the best cultural treatment facilities at that time, *Nanitch Sahallie,* in Keizer, Oregon. This young man came home and completed aftercare. He had a couple of slips, and entered the boot camp in Dillon. After completing the boot camp, he joined the U.S. Marines. He is currently stationed in Iraq, but is doing very well with his life. He was home on leave and plans to enter college when his time in the Marines is up.

Another young man entered our outpatient treatment program. He continued with aftercare, and soon after, began training for the Police Academy in Artesia, New Mexico. He ultimately found a job as a juvenile detention officer at the White Buffalo Detention Center.

Still another young man went off to treatment in Washington State. He is currently playing basketball for one of the leading universities in NCAA-Division 1, and continues to be a role model for young people everywhere. He is a wonderful example of *If there's a problem, let's fix it.*

Many of our young women are doing very well also. We have one young lady who is winning barrel racing titles on the rodeo circuit. Others have found successful jobs and are content being good parents.

Each one of our young people has potential, and their success lies within themselves. They get side-tracked sometimes by the alcohol and drugs and peer influences. But that's why we're here.

—Lynda Beaudry has worked in the chemical dependency field as an adolescent counselor for the past 9 years, and for the last 5 as Coordinator. She previously worked as a Juvenile Officer.

*The **Blackfeet Chemical Dependency Program Adolescent Program** is housed in the Blackfeet Chemical Dependency Program facility in Browning. The adolescent program is comprised of four employees: the clerk/ receptionist; the outpatient./aftercare counselor; the intervention/prevention counselor and the coordinator. The counselors also provide assessments and referrals to anyone between the ages of 12-18 years of age. The program can serve clients up to age 21 if they are in an academic setting. The program is C.A.R.F. (Commission on Accreditation of Rehabilitation Facilities) accredited in the outpatient and assessment/referral areas. For more information call (406) 338-6330 or visit **www.blackfeetnation. com/ Home%20Page/blkft_cheml_ depend.htm.***

"I will continue working with young people because I believe in rehabilitation as opposed to incarceration. We are working with a disease."
—Lynda Beaudry

Tumbleweed:
Answering the Cry for Help

by Sally Leep

Tumbleweed provides crisis intervention, information and assistance to runaway, homeless and at-risk youth in the Billings community. In Fiscal Year 2004, the Runaway and Homeless Youth Program served 1,607 unduplicated youth.

Adolescence can be a challenging time for kids and families. Difficulties and crises often arise as youth search for an individual identity and strive for independence. In support of keeping youth from falling through the cracks, the *Tumbleweed Runaway Program* provides services to runaway, homeless and otherwise at-risk youth and their families.

Runaway and homeless youth are vulnerable to abuse and exploitation and prone to delinquency as a mechanism for survival. Though running away is often attributed to "big city" influences, running away is actually more common in mid-sized communities and is often a cry for help. Tumbleweed is ready to respond to that cry through the provision of specialized social services and by helping youth access direct assistance.

In addition to the Runaway and Homeless Youth Program, Tumbleweed provides services through several other programs.

1. The Street Outreach Program focuses on youth who find themselves on the streets of the greater Billings area. It is the only program of its kind in Montana.
2. The Independent/Transitional Living Program is located in First Step House, where up to five youth are housed and supported by two house parents.
3. The Independent Living Program supports youth prepared to move directly into an apartment or transition to an apartment from First Step House. Three case managers work with youth in the Independent/Transitional Living Program to provide a safe, supportive environment geared to helping youth develop the skills necessary to make a successful tranistion to self-sufficiency.
4. The Tumbleweed Montana Foster Care Independence Program provides supportive services to youth in foster care. Services include life skills assessment and training, mentoring and resources to help youth develop the skills necessary to live successfully as adults in their communities.
5. Through a federal grant under the *Runaway and Homeless Youth Act*, Tumbleweed has formed the Montana Runaway Youth Connection in partnership with the Missoula Youth Homes and the Montana Youth Homes in Helena, as well as with Discovery House in Anaconda. This facilitates provision of human services to runaway and homeless youth throughout the state.

Tumbleweed's services are free of charge and include: crisis intervention; emergency shelter; family mediation; short-term individual and family counseling; adolescent support groups; information, advocacy, and referral; parenting courses; aftercare; and assistance in locating runaway youth and reuniting them with parents/legal guardians. Tumbleweed's crisis counseling and youth shelter services are available twenty-four hours a day, seven days a week.

As we have for nearly 30 years, we will continue to respond to the cry for help and to treat youth with the dignity and respect they deserve. It is our goal to provide the highest quality of service to some of Montana's most vulnerable youth.

For more information, contact Tumbleweed at 406-259-2558.

—Sally Leep is the Executive Director of Tumbleweed Runaway Program, Inc., a non-profit, 501(c)(3) community-based agency founded in 1976.

Tumbleweed Street Outreach

Reaching out to youth, providing support, through non-judgmental intervention.

– ***Street Beat***—*Ensuring safe neighborhoods and providing accessible help for youth.*

– ***Emergency Response***—*Providing care packets, basic medical aid and emergency transportation.*

– ***Lunch Bunch***—*Feeding and building trust with outcast youth who "hang out" in alleyways during school lunch hours.*

– ***Skate Park***—*Using ice water and Power-Aid to open lines of communication, this program provides information on healthy decision making.*

– ***24-hour Hotline***—*Reach the counselor on call: 888-816-4702*

In September 2004, Tumbleweed made 1,527 youth contacts and distributed:

– 15 care packets

– 462 portions of food and drink

– 67 informational items

– 92 items for health/hygiene

The number of street outreach contacts are large because each contact with youth in the skate park, the schools or at various population hang outs counts. Since individual information is not recorded, the numbers reflect contacts as opposed to individuals and therefore, may include duplicates.

Mountain Home Montana

by Gypsy Ray, Executive Director

There is an assumption that homeless youth are part of homeless families, but the truth is, a large number of homeless youth between the ages of 14-21 are on their own. Teenage mothers and their babies are part of that group. This isn't new. Homelessness among youth has been an unaddressed problem for as long as I have served in the social work field. In 1998, the need for housing for homeless teenage mothers in Missoula, Montana and the passion to make it happen culminated in Mountain Home Montana, Inc. (MHM), a private nonprofit organization.

MHM, a transitional housing program for homeless teenage mothers, came together through the hard work of the founding Board of Directors as well as support from the community. Bonnie Hamilton also made a generous gift of her family home. This residential program provides a unique service in Montana by working with homeless teenage mothers who do not qualify for other services, often due to their age.

Mountain Home began operations on August 7, 2000. Located on a one-acre lot, it has 6 bedrooms, 3 bathrooms, a kitchen, dining-, living- and play rooms, offices, storage and a play yard. It is staffed by an executive director, a case manager and shift workers who provide 24-hour supervision and training. Four beds are reserved for homeless teenage mothers, leaving two for other referrals. These beds, too, are often filled with homeless youth. Mountain Home provides family style dining, and coordinates on-site parenting classes, life skills classes, nursing services, therapy and other social services.

The organization's three-year strategic plan includes the development of the one-acre property. Two of the projects included in the strategic plan will be implemented as phases. Phase I—a drive-through coffee shop will provide job training opportunities and program revenue; Phase II includes independent living apartments. Mountain Home Montana is also creating follow-up services for program graduates.

In coordination with the University of Montana, Mountain Home recently completed a three-year program evaluation of the operations between 2000-2003. The results clearly show that Mountain Home *is* making a difference in the lives of teen mothers and their babies! The full report will be published in an annual report later this month and posted on Mountain Home Montana's website at *www.mountain home mt.org.*

Results:

— 38 teen mothers at an average age of 17 participated in the program;

— participants listed having enough food to eat and a safe place to sleep among the most important services the program provided;

— second pregnancies were delayed; and

— teenage mothers were more prepared for independent living.

For more information, contact Gypsy Ray, Executive Director at gypsyray@blackfoot.net or 406-541-4663.

The Office of Public Instruction (OPI) sponsors Montana's Homeless Education Program. The purpose is to ensure that "each child of a homeless individual and each homeless youth has equal access to the same free, appropriate public education, including a public preschool education, as provided to other children and youths." At last report (1999), the Montana Homeless Education Program counted 2,459 homeless children and youth in Montana's schools, including those living in shelters, doubled up or other. The number of homeless kids in Montana has increased each year, as it has nationally.

Source: www.dphhs.state.mt.us/homeless_in_montana.pdf

***MISSION:* Mountain Home is committed to providing a home and supportive services to homeless young women aged 14-19 who are pregnant or parenting one child. Participants access community resources, learn independent living skills, develop parenting skills, continue their educations and improve their employment skills in order to obtain permanent housing and ultimately to be self-sufficient.**

Homeless Kids

The National Mental Health Association states that families are the fastest growing segment of the homeless population, accounting for almost 40 percent of the nation's homeless. The numbers captured in Montana were even higher. The 2003 Survey of the Homeless *identified 1,426 individual family members, which included 577 children under the age of 18.*

— 144 families had one child between the ages of 0–6;

— 52 families had two children under age 6.

— 40 women were pregnant.

Homeless children face hardships that include frequent mobility, poor nutrition, substandard living conditions, emotional stress and lack of access to health care. Parents engaged in a daily struggle to secure shelter for the night may have difficulty meeting even such basic needs as school supplies and appropriate clothing. These factors often result in multiple problems in the education setting and predispose children to school drop-out, risk behaviors including drug and alcohol use, teen pregnancy and engagement in the juvenile justice system.

Source: Homeless in Montana 2004. www.dphhs.state.mt.us/homeless_in_montana.pdf

Youth Taking Flight

Youth Taking Flight is a collaboration of Missoula social service agencies and schools focused on improved supports for at-risk youth transitioning to adulthood. The group designed and carried out three assessments over a period of two years in order to determine how many Missoula youth were homeless and what their needs were. The first survey was done in April 2002, and attached to the statewide Survey of the Homeless. This was followed by a January-February 2003 service provider survey, and an October 2003 *Homeless Youth Assessment*. For these purposes, homeless youth were defined as "independent youth ages 14 to age 21 who lack a fixed, regular, and adequate nighttime residence." With help from the University of Montana's social work program and Rob Snow of the Prevention Resource Center VISTA Program, homeless youth were questioned on topics ranging from where they were sleeping to whether Missoula's services met their needs. The 2003 assessment included responses from 67 homeless youth.

Among those surveyed, about half were connected with a local service agency; the other half were not. Approximately half were under 18 years. Those under 18 were typically "couch surfing" through the homes of friends or acquaintances, and did not tend to have formal ties to services. The service contacts that did exist for the younger group were generally through a school or occasional contact with an agency.

Those 18 years of age and older were more likely to live on the streets, in their cars, under bridges or in camps. Approximately 10 of these youth planned to leave Missoula for warmer climates once winter arrived.

Best estimates indicate that there are around 70 homeless youth in the Missoula area at any given time.

Among those connected to services, about 1/3 were male and 2/3 female. Those peripherally tied to the system or who were on the streets were approximately 2/3 male and 1/3 female. The vast majority (86%) were from Montana. All reported multiple unstable living situations that ultimately resulted in homelessness.

Striking differences were noted between the group connected to service systems and the group that was not. Youth connected to services were predominately female and expressed concern about their mid– and long-term futures. Their concerns included long-term employment, college or formal training, daycare, permanent housing and being able to secure identification so that they could access employment and services. Barriers identified by this group included their age, paperwork, the cost of services and the hours services were available. Providers identified additional barriers among this group, including lack of job readiness and the need for supportive environments where youth could gain work and study skills.

Youth who were *not* connected to services were predominately male and lacked knowledge of their options. They exhibited suspicion of outsiders and expressed concerns about their safety. This group identified needs that included: food, water, bathrooms, shelter; short-term employment; transportation; the ability to secure identification; and access to a mail box and contact points. They described the barriers to services as lack of knowledge, lack of trusting relationships, and "strings attached to services."

Youth Taking Flight has three goals, which were developed as a result of the needs assessment: increased access to work experience and employment; increased access to physical and mental health services, and reconnecting homeless youth in an approach consistent with needs assessment recommendations. Action plans are currently being developed.

The Youth Taking Flight Needs Assessment Committee was chaired by Gypsy Ray, Executive Director of Mountain Home Montana. For more information, contact Joe Loos at 406-880-6760, Geoff Birnbaum, Executive Director of Missoula Youth Homes at 406-721-2704 or Jim Morton, Executive Director of District XI Human Resource Council at 406-728-3710.

Financial Resource for Families

Although poverty exists in both rural and urban areas, the Internal Revenue Service is struggling to understand challenges distinct to rural America. Northcentral Montana, through its Community Ventures coalition, has been identified as one of five regions that the IRS will work with in its Rural '05 Strategy. The centerpiece of the strategy will be increasing use of the Earned Income Tax Credit (EITC). The EITC is a federal income tax credit that can be claimed by eligible low-income workers. The credit reduces the amount of tax an individual owes, and may be returned in the form of a refund. For more information, visit: ***www.irs.gov/individuals.***

On Their Own

by Brian Kraft, MFCIP Coordinator, Tumbleweed Runaway Program, Inc.

When I graduated from high school at age 17 and went off to a college nearly 1,000 miles from home, I never gave a thought to the fact that my parents and family would be far away. It was the first time in my life that I had the opportunity to be on my own for an extended time and I viewed it as an exciting adventure and approached it without fear. In the back of my mind, I knew that if anything disastrous happened, my parents were just a phone call away. I trusted that they would have the answers (or any other help) I might need. And independent as I was, a time or two I did have to make that phone call for advice . . . or money.

I was fortunate. My independence happened gradually and I had a safety net if I needed it. I didn't realize it at the time, but not all young adults share my experience. Today there are approximately 500,000 children in foster care across the United States. Of the 500,000, approximately 16,000 age out of care every year. The majority of youth who turn 18 in the care of the state have virtually no family or support systems to help point them toward responsible, successful adulthood. Research indicates that young people aging out of care are vulnerable to homelessness, irregular employment, victimization through crime and exploitation and dependance upon various types of public assistance. In recognition of these issues and the larger consequences, Congress passed the *Chaffee Foster Care Independence Act* in 1999.

The Chaffee Foster Care Independence Act serves as a bridge from adolescence to young adulthood and helps prepare young adults in the care of the state for responsible, successful adulthood. The Act gives each state money to provide services to these young adults; the amount is based on population. Each state is required by law to use the funds to help eligible youth aging out of foster care prepare for independence.

Montana has developed the Montana Foster Care Independence Program (MFCIP) as the vehicle to provide this program to eligible youth, who include those up to 21 years of age who have aged out of the foster care system, youth age 16 or older who are in foster care; youth adopted from foster care or appointed a guardian after attaining age 16, and youth who are or have been under tribal court jurisdiction and meet the same eligibility criteria listed above.

The mission of the MFCIP is "to assist Montana's foster youth in gaining the necessary life skills to make a successful transition into adult community living by providing a variety of services to youth and those who work with them." In support of this mission, a variety of services are provided to youth and to those who work with them. The State of Montana contracts with agencies to provide these services. Tumbleweed in Billings is the MFCIP contractor for regions I and III (the eastern half of the state). The services provided include: life skills assessments and training; transitional living plans; mentors; incentive payments; stipends for secondary school educational expenses; vocational training and job readiness assistance; education and training vouchers; board and room funds; and travel assistance.

Tumbleweed is currently providing MFCIP services to 103 youth. Another 200 have chosen not to participate in the program.

I can't imagine what it might have been like to enter into adulthood with no one to help me. I probably would not have attempted to obtain a college education and my existence today would, I'm sure, be meager in comparison. Thankfully, the Chaffee Independence Act passed. The youth we serve give us a constant reminder that the money and time are well spent.

For more information contact: Jane Wilson, DPHHS Child and Family Services Division, MFCIP Program Officer, Helena, 406-444-5956, or Brian Kraft, Tumbleweed MFCIP Program Coordinator, Billings, 406-259-2558

Supporting Youth in Out-of-Home Care

A strong educational foundation is essential for success. That's especially true for children and youth in the foster care system, who often slip behind their peers in school. Minimizing enrollment delays and providing additional supports to children and youth in care can begin to close this gap. Child welfare agencies may be able to bring these resources to children and youth in care through the McKinney-Vento Homelessness Assistance Act. This Act provides a stream of federal funding for an array of supports, including but not limited to tutoring, transportation and cash assistance to ensure the participation of homeless children and youth in elementary and secondary school. McKinney-Vento also ensures that children are entitled to continued enrollment in their home school or immediate enrollment in a new school.

Each school district is required to appoint a McKinney-Vento liaison. The state education coordinator can provide contact information. A list of state coordinators is available online at http://www.serve.org/nche/states/state_resources.php.

For more information:

- *—www.ed.gov/programs/homeless/guidance.pdf.*
- *—http://www.naehcy.org/*
- *—www.nlchp.org/FA_Education*

Source: http://www.cwla.org/

Grandparents Raising Grandchildren

by Sandra J. Bailey and Annie Conway

Grandparents' involvement in raising grandchildren is nothing new, but grandparents as primary caregivers is a growing national trend. Western states in particular are experiencing a dramatic increase in the number of households headed by grandparents, with more than 6,000 Montana grandparents raising their grandchildren—a 53.8% increase in a 10 year span (Census, 2000). Grandparents are raising grandchildren in Montana's larger cities, rural communities, and on reservations. They include working professionals, retirees, those working minimum wage jobs, and they range in age from 39 to 86 years.

There are many reasons grandparents are called upon to care for their grandchildren—child abuse or neglect, parental chemical dependency, chronic illness, teen pregnancy, abandonment, death of a parent, economics, military deployment, divorce, and parental incarceration (Weber & Waldrop, 2000). Often there is a combination of factors.

Grandparents step in, but for most, at a cost. Grandparents often experience physical and emotional health concerns, legal concerns and difficult family relations. They may have to wade through a number of systems just to enroll the child in day care or school, apply for medical insurance, obtain financial assistance or to obtain custody or guardianship. Additionally, grandparents are often faced with providing for the child on a fixed income and thus face financial strain. More than 38 percent of grandparents who are the primary caregivers for their grandchildren are living below the poverty line (Kirby & Kaneda, 2002). They are forced to find ways to meet the needs of the new family, while dreams of retirement fade.

Some literature suggests that difficulties controlling grandchildren's behavior, coping with generational differences in values and parenting styles, and assuming firm parental control can lead to psychological distress in grandparent caregivers (Sands & Goldberg-Glen, 2000). Grandparents may feel out of touch with changes in parenting and discipline styles, the ever-changing educational system, and even pop culture as it relates to how children behave and interact socially. Many feel socially isolated from their peers. In rural settings, this is compounded by few opportunities to participate in social networks, poor physical health, and transportation problems (Kelley, Whitley, Sipe, & Yorker, 2000; Revicki & Mitchell, 1990). Grandparents may be able to prevent or manage stress with the support of community resources, but there are inadequacies in public programs designed to meet their needs (Sands & Goldberg-Glen, 2000). In Montana, we are striving to meet these needs through the development of a statewide project.

The *Montana Grandparents Raising Grandchildren* project started in 2002, and is coordinated by MSU Extension Family & Human Development. Partners include AARP, the Department of Health & Human Services, the Head Start Collaboration, the Office of Public Instruction, tribal partners and Child Care Resource and Referral agencies. Through the partnership, we are providing information and resources to communities statewide, so that they can support grandparents raising grandchildren. A major focus is developing support groups and parenting classes where grandparents can share their stories, find support, get updates on child development and parenting and learn about resources. To date, 77 individuals have been trained to lead support and education groups; eleven support groups are in operation. The project also puts out a bimonthly newsletter, a fact sheet and offers periodic educational seminars.

For more information, contact Sandy Bailey at baileys@montana.edu; phone (406) 994-6745 or Annie Conway at aconway@montana.edu; phone (406) 994-3395.

—Sandra J. Bailey is the Family & Human Development Specialist, and Annie Conway is the Project Coordinator for the Grandparents Raising Grandchildren Project through the Montana State University Extension Office.

Montana Grandparents Raising Grandchildren

Of the 11,098 grandparents living with their grandchildren (under age 18) in Montana, 6,053 (55%) are responsible for them.

The length of time they've been responsible varies:

— 947 have been responsible for less than 6 months;

— 781 for 6-11 months;

— 1,516 for 1-2 years;

— 814 for 3-4 years; and

— 1,995 have been responsible for 5 years or more.

Source: US Census Bureau. Census 2000. www.census.gov

Resources for Grandparents

http://www.montana.edu/wwwhd/grg/index.htm Montana Grandparents Raising Grandchildren Project website.

http://extn.msu.montana.edu/ Montana State University Extension website

http://www.aarp.org/confacts/programs/grandraising.html AARP Grandparents Raising Grandchildren website.

Early Childhood

by Mary Jane Standaert, Director, Montana Head Start/State Collaboration

Programs that enroll a child and engage the parent are more apt to prevent trauma—or to deal with it successfully if it comes to that.

Early childhood professionals play an important role in protecting and nurturing young children and promoting social, emotional, cognitive and physical development. In addition to their role with parents and children, evidence suggests that an early childhood program that reaches out to parents may also be the best child abuse and neglect prevention strategy (Center for the Study of Social Policy, 2004). In other words, the single most effective abuse prevention strategy supports *families*.

Quality early childhood programs emphasize positive relationships and promote resilience. There is a synchrony in quality early childhood programs that makes them a haven for those experiencing trauma as well as for those in normal circumstances. For children and families on the edge, this relationship may be the only lifeline they have. A program that values the child, the parents and their concerns and that responds to parents' needs, understands child and parent development and focuses on strengths will be much more successful when and if crisis occurs. Of course, early childhood programs can't be all things to all people, but programs that enroll a child and engage the parent are more apt to prevent trauma – or to deal with it successfully if it comes to that.

The concept behind Head Start and Early Head Start (HS/EHS) is to improve the successful development of the child by strengthening the family. HS/EHS targets children and families at or below federal poverty level, and includes children with disabilities as well as children with disabling conditions, whether physical, cognitive or emotional. There are various protocols in place to meet the needs of children suspected of or diagnosed with developmental delays.

Head Start and Early Head Start have spent many years creating a system capable of responding to the needs of children and families dealing with trauma and other difficult situations. At the beginning of the program year, each HS/EHS family is assisted in formulating a plan designed to foster growth and learning. Homeless children and their families are assisted in locating stable housing, then supported in seeking and holding employment. Nutritional concerns are addressed and all children are required to have physical, dental and cognitive screenings with follow-ups identified. Each child is assigned to a family advocate who tracks progress and works with the teacher to gain a full understanding of the child and family. If a child is suspected of being abused or neglected, the system is in place to address that need and locate help to assist the family.

In addition to HS/EHS, here are many types of early childhood programs, from private preschools and childcare homes to early intervention and home-visiting programs. These programs have access to a wide network of support services that include professional development, training and technical assistance, mentoring, state and federal financial assistance, various grant opportunities, program, staff and child assessments and evaluation procedures, and guidance at a number of levels.

Resources are available to early childhood professionals through local Child Care Resource and Referral (R&R) programs, which provide a hub of community resources for teachers and caregivers. The state also offers low-income families a special needs child care subsidy individualized to meet a child's particular needs. Children with special health care needs may be eligible for services offered by the state and/or local health departments. Child Care Plus+, the Center on Inclusion at the University of Montana, is another excellent resource primarily geared to providing training and information. These very talented and responsive people are well known throughout the United States. Numerous state efforts continually look for better ways to meet Medicaid needs, coordinate comprehensive services, train and support the early childhood work force, increase advocacy and include frontline staff.

For more information, contact Mary Jane Standaert, Director of the Montana Head Start/State Collaboration Office of the Department of Public Health & Human Services at 406-444-0589 or mstandaert @state.mt.us.

Early School Success and Child Wellbeing

A Statistical Portrait of Well-being in Early Adulthood*, a new* CrossCurrents *data brief from the Child Trends DataBank, examines indicators of well-being and development among children entering kindergarten and describes changes in these indicators as children move from kindergarten to first grade. The brief pays particular attention to differences in progress by gender, race and ethnicity, language spoken at home, disability status, and socioeconomic status. To view this data brief, as well as updates on violent crime victimization, visit the Child Trends website at* http:// childtrendsdatabank.org.

In the early childhood world, Head Start and Early Head Start serve some of our society's most fragile families and provides them with crucial and comprehensive services.

Efforts that promote family strengths and resiliency produce more positive results than programs that concentrate on deficits.

For more information on quality early childhood contact:

- *The Child Care Resource and Referral Network: 549-1028*
- *Head Start Collaboration: 444-0589*
- *Early Childhood Project: 994-1992*
- *Child Care plus+: 800-235-4122*
- *Early Childhood Services Bureau: 444-1828*

Take an Extra Second: *Preventing the Silent Epidemic*

by Stacy Rye and Marilyn Patrick

October 10th, 2004 marks the ten-year anniversary of Matt Patrick's brain injury. Marilyn, his mother, tells his story.

Matt was fifteen in 1994, the most popular kid in his class. It was a Monday and he was coming home from a nearby friend's house on his dirt bike. Because it was close, he didn't bother to put on his helmet.

Matt's grandmother called Marilyn around 7 P.M. "Where's Matt?"

"At a friend's house," Marilyn responded.

After a long silence, her mother-in-law said, "Marilyn – there's been an accident. I just heard the news on the police scanner."

At that moment, someone rushed into the house, screaming that Matt had been in an accident. Tony, Matt's dad, ran down the street. She remembers Tony yelling, "Who did this?" When she found her son unconsciousness on the ground, left eye big as a golf ball, she remembers screaming. The police helped her into the car and drove her to St. James Hospital in Butte.

Traumatic brain injury (TBI) is a silent epidemic. It is estimated that there are more than 10,000 people in Montana currently living with the effects of an accident. More often than not, TBI is the result of a car accident—more than half of those accidents involved alcohol. The effects of brain injury are highly varied—sometimes permanent, sometimes not. While there are no universal rules for how a brain injury will affect a particular person, the rule of thumb is that the longer the coma, the more severe the brain injury and the more permanent the impairments.

After an hour, doctors came to lead Marilyn and Tony to Matt's room. They'd cut off his jeans and shirt. Matt had had a tracheotomy and a hole drilled in his skull for the ICP monitor. It was the most horrific sight Marilyn had ever seen. She didn't even recognize her son. "All I could see was this child laying there all bloodied and bruised. I didn't understand yet that he had a brain injury. I didn't understand what was to follow."

A common type of brain injury is post-concussive syndrome, also called mild or moderate brain injury. Loss of consciousness may occur for a few minutes or a few hours. Many people have experienced a mild brain injury through sports (football, baseball, skiing, horseback riding), riding a bicycle without a helmet, car or motorcycle accidents. Dizziness, balance problems, forgetfulness, lack of a normal attention span, mood swings, irritability and headaches are common symptoms. Often people recover fully from a mild brain injury, but cumulative mild brain injuries often turn symptoms into permanent impairments.

After three or four weeks in Intensive Care, Matt was slowly waking up and the nurses started talking to Marilyn about rehabilitation. She says it was at that point that things started coming to her. "Matt couldn't speak. There was no recognition. You know that sparkle in the eye? Gone. This was a different person. He's been a different person ever since.

We often think that when the brain is injured, it can mend completely, like a broken arm, but brain cells do not regenerate. Moderate to severe brain injuries—often found in individuals who have suffered injuries involving coma—are likely to leave permanent impairments and limitations . . . physical, cognitive and/or psycho-social. Rehabilitation includes work with many therapists to develop strategies geared to dealing with everything from short-term impairments to strategies that will help an individual live independently and—sometimes—return to work.

Matt was transferred to Community Medical Center's rehab unit and then the Bridges Program, where he stayed for four months. Ultimately, Marilyn moved to Missoula to help her son. "Initially, Matt was non-responsive. We had a hard time with simple things like asking him to kick a ball. He'd forget what he was supposed to do by the end of the sentence." Matt relearned how to speak in January. He went back to school the next fall.

Matt is lucky that he has a family that was willing to navigate the system to put all of the puzzle pieces in place. After Matt graduated from high school, he went to the Headways Program at St. Vincent's in

Continued on Page 13

TBI Resources

The Brain Injury Association of Montana is a non-profit dedicated to education, referrals, resources, prevention and advocacy for people with brain injuries, their families and the general public. We maintain a hotline to call for help and have ten associated support groups around the state.

The Brain Injury Association of Montana: 1280 South 3rd Street West, Suite 4, Missoula, MT 59802, (406) 541-6442, (800) 241-6442 (In Montana) www.biamt. org (Website) biam@biamt.org (Email)

Local help is often available, so please call the BIAM office for more information. ***Support Groups*** *meet in the following cities once a month: Bozeman; Billings; Butte; Great Falls; Miles City; Missoula; Hamilton; Helena; Kalispell; Libby and Plains.*

The Brain Injury Association of America*: www.biausa.org*

Taking an Extra Second

Continued from Page 12

Billings where they encouraged Matt and Marilyn to consider living environments where he might be able to live independently as an adult. In 1999, Matt moved into his own apartment in Helena with the help of the Medicaid Waiver Program and Westmont, a nonprofit that provides supportive living services. He has caregivers to help support his independence and his own successful vending machine business. He is looking at going to school; he knows he wants to do more.

"I don't want it to stop here, I want to help educate, help people understand brain injury and helping them out and making it more apparent to people so we're not invisible. Whatever can be helpful to prevent brain injuries—little things like seatbelts and helmets so people don't have to go through what I've had to adjust to." —Matthew Patrick

There is no cure for brain injury, which makes prevention absolutely critical. Mathew Patrick wants people to know the little things they can do to prevent brain energy. He says to take an extra second to put on your seat belt or strap on a helmet. It is estimated that it costs over $4 million dollars to care for someone over the course of a lifetime with a severe brain injury, from initial rehab to a lifetime of supported living. There are no estimates for the cost to a family once a loved one has a severe brain injury.

Marilyn finishes her story by saying, "It's the lot I drew. If I can ever prevent someone else from drawing the same lot I will do it. I just don't like fall anymore. It's when Matt got hurt. Now fall is just the sad time of year."

Author's note: As I was working on this article, it became clear that a personal story would illustrate the facts about brain injury much better than the simple communication of generic particulars about the three levels of brain injury. Marilyn Patrick, a Board member of the Brain Injury Association of Montana, very generously shared her family's story. Thank you to the Patrick family. —Stacy Rye

Traumatic Brain Injury (TBI)

Source: Center for Disease Control and Prevention *www.cdc.gov*

A blow or jolt to the head can result in a traumatic brain injury (TBI), which can disrupt the function of the brain. Concussions, also called "closed head injuries," are one type of TBI. Approximately 75% of TBIs that occur each year are concussions or other mild forms. An estimated 300,000 sports-related brain injuries of mild to moderate severity occur in the United States each year. TBIs also contribute to a substantial number of deaths and cases of permanent disability annually.

Each year in the United States, an estimated

- — 1.4 million people sustain a TBI. Of those, 230,000 are hospitalized and survive, which is more than 20 times the number of hospitalizations for spinal cord injury, another key disabling injury.
- — 50,000 people die from a TBI.
- — 80,000 to 90,000 people experience the onset of long-term or lifelong disability associated with a TBI (Thurman et al. 1999).

Among children ages 0 to 14 years, TBI results in an estimated

- — 3,000 deaths,
- — 29,000 hospitalizations, and
- — 400,000 emergency department visits.

In Montana, there were an estimated 452 cases of nonfatal TBI in 1998.

Leading causes of TBI:
- ***— Vehicle crashes,***
- ***— Firearm use, and***
- ***— Falls***

TBI Implementation Grant

Montana has the second highest rate of traumatic brain injury (TBI) in the nation. The Brain Injury Association of Montana estimates that there are 10,920 Montanans living with a long-term disability as a result of TBI.

Through the Traumatic Brain Injury Implementation Grant, Montana is working with government agencies, providers and consumers to gather data about TBI and to determine what services are needed most. The goals are to provide consumers and their families with access to a system of coordinated TBI services and resources, address TBI needs within the Native American medial and service delivery system, increase public awareness and provide training andinformation.

For more information, contact Cecelia Cowie, Senior and Long Term Care Program, at 406-444-4150 or ccowie@state.mt.us.

Push and Pull Factors: *Preventing School Drop-Out*

by Claudia Morley, Principal, Project for Alternative Learning

The Search Institute's 40 Developmental Assets are concrete, common sense, positive experiences and qualities essential to raising successful young people. These assets have the power during critical adolescent years to influence choices young people make and help them become caring, responsible adults.

The Developmental Asset framework is categorized into two groups of 20 assets. External assets *are the positive experiences young people receive from the world around them through family, school, congregations, neighborhoods and youth organizations. They fall into four broad categories: support; empowerment; boundaries/expectations; and constructive use of time.*

The 20 internal assets *identify characteristics and behaviors that reflect positive internal growth and development. These also fall into four broad categories: commitment to learning; positive values; social competencies; and positive identity.*

For more information, visit the Search Institute at: http://www.search-institute.org/

Of the 45 students graduating with the class of 2004, 38% are enrolled in post-secondary education, an increase of 20% over the past two years. With implementation of our new tools, we are optimistic that we will retain more students in school and see another increase in students who transition into post-secondary education.

Students drop out of school for a variety of reasons. Research examining the reasons indicates the existence of "push and pull effects" in many schools.[1] Students who drop out often cite *push factors* as reasons for leaving school. These include situations or experiences that heighten students' feelings of alienation and failure, such as problems getting along with teachers, suspension and expulsion, low grades, and disliking school.

Pull effects consist of external factors that distract students from the importance of staying in school, including pregnancy, financial responsibilities, caretaking responsibilities and employment.

These push/pull factors apply to many of the students enrolled in Helena School District #1, but fortunately, students in this district have another option when they find themselves being pushed or pulled toward school dropout. PAL (the Project for Alternative Learning) is an option for high school youth identified as being at-risk of not completing high school. The purpose of the program is to give students one more chance to reengage in learning and to earn a high school diploma.

PAL's mission is to facilitate academic growth through career exploration and cross-curricular activities, and to ensure that all students are prepared to transition into further training beyond high school. In support of that mission, PAL is adding strategies to its toolbox this year, which were learned through participation in the MBI (Montana Behavior Initiative) and the Search Institute's 40 Developmental Assets training. Both philosophies utilize strategies that individualize academic instruction and personalize the learning environment.

In a sense, assets are building blocks that assist young people as they grow into healthy, caring and responsible adults. Assets are positive factors in young people, families, communities, schools and other settings found to be important in promoting young people's healthy development.

On the first school day at PAL this year, students were greeted with *"Take a second - Make a difference,"* (Kansas Health Foundation). Specific activities by the Asset Team were introduced with the intent of making everyone feel valued, accepted and safe. The PAL Asset Team is comprised of nine students and four staff members. Parents also got into the act during *Back to School Night*, where they met the staff and were introduced to the assets concept through a game of 40 Assets Bingo. It was a very positive way for parents to mingle, to meet one another and to be introduced to the assets framework.

For the remainder of the year, a new asset will be introduced every three weeks. Specific activities will be designed to teach and reinforce the *asset of the block.* Since this is the first year we've used this strategy, we've been asking ourselves a lot of questions. Will these strategies make a difference? Will students develop a relationship with at least one caring adult? Will GPAs improve? Will students begin to like school? Will more stay in school to earn a diploma? And, will more students enroll into post-secondary training?

Check back next fall to hear the results—or contact me now if you want to learn more about alternative education in Montana. For more information, contact Claudia Morley at 406.324.1630 or *cmorley@helena.k12.mt.us.*

Source:

[1] *Promoting School Completion:* Counseling 101 Column. *Principal Leadership Magazine*, Vol. 4, Number 5, February 2004. National Mental Health & Education Center. *http://www.naspcenter.org/principals/nassp_completion.html*

Diversity Week 2004

by Scott Mathews

Diversity Week gives students a chance to hear stories and gain strength in their own voice while growing and learning about other cultures and differences. —Amanda Tripp, Respect Club President

As I was completing my first year as Flagship Coordinator at Missoula Big Sky High School, I had a conversation with my high school counselor and mentor, Mr. Beggin. We laughed about the things that hadn't changed in the 17 years since I'd graduated, and then I asked him to reflect on his 35+ years in education and offer some advice.

"Two things," he said. "High school students aren't the same as they were when you were going to school. They are more informed than they have ever been. Information is traveling faster to them—a lot faster. Second—to get the most from them, give them a lot of responsibility. They like it, and most are ready for it."

One of the biggest projects I advise through the Flagship Program each year is Diversity Week. The week is planned and organized by Big Sky students who participate in the Flagship-sponsored Respect Club. Last year, Diversity Week included 52 presentations, a school assembly, performances, speakers and workshops for teachers and students.

The goal of Diversity Week is to present firsthand information about different cultures, nationalities, religions, generations, disabilities and sexual orientations. Organizing this event requires an incredible amount of planning and work. Students plan the week, organize the speakers and execute the presentations. They are incredibly motivated and organized. Cooperation from the school administration, faculty and staff are vital as well.

"Diversity Week provides a venue for appreciation and acceptance of the diversity within our school and community," said Amanda Tripp, Respect Club President. "We make every effort to represent the different groups at Big Sky, groups that people might not always see as a significant part of our community."

Last year, Big Sky students and staff gave presentations on such topics as Native American cultures, spinal cord injuries, agricultural education and a variety of nationalities. Exchange students gave presentations on their native countries, which included Germany, Ecuador, Brazil, Turkey and Denmark.

"It was nice to have a chance to tell people about my country," said Yordana Cantos, an exchange student from Ecuador. "Before this, a lot of people assumed I was Mexican because they would hear me speaking Spanish and see that I had darker skin. Once people got to know us, they realized we weren't that different from them."

Representatives from a variety of community agencies and organizations filled out the rest of the presentations, which included natives of every continent, perspectives on fourteen different religions, topics such as homelessness, media literacy and age discrimination. During Diversity Week 2003, we learned that placing members of the community with differing viewpoints in a panel format offered students a broad perspective.

A post Diversity Week survey conducted by the Respect Club revealed that 82 percent of students and 71 percent of staff found the week valuable. Though Diversity Week is not without its critics,most believe it promotes tolerance.

"I think that Diversity Week definitely helps bring understanding and acceptance to the student body," said Leland Earls, a sophomore at Big Sky.

For more information, contact Scott Mathews at bshsflagship@ mcps.k12.mt.us or 406-728-2400, Extension 8089.

—Scott Mathews is in his second year as the Flagship Youth Development Coordinator at Missoula Big Sky High School. Flagship is operated by Western Montana Addiction Services with funding from local, state and federal sources. There are currently programs in place at 10 schools.

"Our students live with diversity every day—locally, nationally and worldwide—through the different avenues of communication. It is important that they are exposed to diverse ideas in a safe setting." Paul Johnson, Principal, Big Sky High School

A Resource for Parents

The evidence is clear, family involvement in schools matters —Linda McCulloch, State Superintendent of Schools.

State Superintendent Linda McCulloch has launched a new webpage to help Montana parents with their children's education. *"Parents are children's first and most important teacher,"* says McCulloch. *"For Montana's children to be successful students, a strong school and family partnership is essential. OPI's new webpage for parents can help."*

For more information, visit: www.opi.state.mt.us/parents

Kudos . . .

to the Office of Public Instruction for hosting the first ever Indian Education Summit October 15–16 in Helena. The Summit convened educators and leaders from across the state to begin developing an action plan to close the achievement gap for American Indian students, and to ensure that schools can successfully implement the Indian Education for All Act.

Montana Meth Watch

by Jean Branscrum, Health Policy Advisor to Governor Martz

From the start of her administration in 2001, Governor Judy Martz was determined to define a plan to eradicate meth from Montana's communities. She began by initiating a partnership with the Montana Attorney General in the Fall of 2001 to form the Alcohol, Tobacco, and Other Drug Control Policy Task Force. Their final report, Comprehensive Blueprint for the Future, a Living Document is online at www.discoveringmontana.com/gov2/css/drugcontrol.

In June 2004, Governor Judy Martz hosted a statewide Methamphetamine Summit where professionals in law enforcement, prevention, treatment and education discussed meth-related problems and defined solutions.

Methamphetamine in Montana

— Meth is increasingly available and considered the most significant drug problem to local law enforcement and a considerable public health care issue.

— Nine percent of high school youth indicate they have used methamphetamines. (YRBS)

— Many counties in Montana report that at least 50% of the child abuse and neglect investigations conducted in the past year involve methamphetamine-impacted families. Some counties report that 50-75% of children placed in foster care are in placement because of parental meth use.

— Ten years ago, 15% of those treated in state-approved community chemical dependency programs were addicted to meth; by 2003 that number had increased to 29%.

— The number of meth labs busts increased from 16 in 1999 to 122 in 2002. In 2003, the 89 labs busted cost taxpayers $327,500 in clean-up fees.

— Meth-related crimes have inundated the court system and filled prisons. About 85 percent of inmates in the Montana women's prison are there, at least in part, because of methamphetamine.

Montana is counting on a new program to be an effective strategy in combating the methamphetamine problem in communities across the state. Governor Martz recently announced the launching of *Montana Meth Watch* at a regional methamphetamine summit in September. It promises to help stop production of methamphetamine by small labs within the state, reduce the availability of meth in communities and increase public awareness.

Methamphetamine is a serious and growing threat to Montana. It is increasingly available because it is cheap to make and all ingredients necessary can be found in local retail stores. Limiting access and reducing theft of the products used in the illegal manufacturing of meth is a focal point of Montana Meth Watch.

Modeled on a successful program designed in Kansas, retailers are the cornerstone of the program. They are provided with signage, product management tips and training materials for employees and managers. Through voluntary participation and partnership with law enforcement, retailers become part of the solution by stopping precursor products from reaching the hands of meth cooks. Retailers reap the benefits of safer stores, better customer relations, reduced theft and improved employee and community awareness.

Governor Martz was quick to act on the recommendation to implement a Meth Watch program upon learning about its success in Kansas and Washington. As the Governor's Health Policy Advisor, I was asked to lead the charge to implement the program by approaching retail organizations to determine their interest. After gaining widespread support, a Montana Meth Watch Leadership Partners Team was formed of 22 state, tribal and federal agencies, business organizations and law enforcement associations.

The Montana Department of Public Health and Human Services (DPHHS) stepped forward to coordinate implementation of the program, including administering community grants. The Department also expanded work contracts with the statewide network of 15 prevention specialists to include Montana Meth Watch.

— Through resources from the Consumer Health Care Products Association, Montana has created Montana Meth Watch posters, brochures and decals for retailers, and a training video.

— Materials will be ready for display in stores across Montana in mid-November.

— Information on Montana Meth Watch will be available on-line in November at www.Montanamethwatch.com.

— 15 communities will receive up to $500 in grant monies to assist implementation efforts. Recipients will be announced during Red Ribbon Week.

For more information, contact Jackie Jandt, Project Coordinator, at 406-444-9656 or jjandt@state.mt.us for more information.

Family Drug Courts:
An Alternative for Montana

by Samantha Walsh, DPHHS Child Protective Services

If you think methamphetamine does not impact you, think again. While most Montanans never come into direct contact with methamphetamine, they are certainly feeling the toll of its sweeping familial, social, economic and environmental costs.

Methamphetamine is particularly destructive to the innocent children found in cars, homes or motels where manufacturing and use takes place. Before the environmental hazards of methamphetamine were understood, many of these children were simply turned over to relatives or neighbors without assessment of the toxic and emotional impacts they were experiencing. Law enforcement agencies around the state are now working collaboratively with Child and Family Services to assess the needs of these Drug Endangered Children.

In response to rising drug use, the first Family Drug Court was established in Yellowstone County in 2001 with the help of Judge Waters and the Court Assessment Program. Family Drug Court is based on the criminal model, but diverges by holding treatment team meetings to include various legal, mental health, child protection and treatment professionals. Team members meet weekly to discuss the 20 families (including 62 children) participating. The goals of the Drug Court Program are multifaceted and include increasing the court's influence on child abuse and neglect cases while promoting child safety by reducing substance abuse—and subsequent child abuse and neglect. Drug Court has proven successful with children and families by decreasing recidivism, keeping children safe and families intact when possible. The true signal of success may be the fact that children involved with drug court spend significantly less time in foster care.

Consider an all-too-familiar story. Robin is 26 years old, the mother of seven and a current drug court participant. She came to the attention of Child and Family Services in 2003 due to her methamphetamine and prescription drug use. She had lost one daughter to SIDS and a son to the complications of a premature birth attributable to her drug use. Robin's living children are ages 11, 10, 7, 1, and 4 months. Her three oldest children are with her mother; her youngest are at home with her and her husband, who is also a drug court participant. Robin's first husband, father to the three oldest children, committed suicide.

Robin began using alcohol at age 14 before moving on to opiates, methamphetamine and cocaine by age 17. Her drugs of choice are prescription drugs. Robin's first experience with treatment was in 1999, the first of three in-patient treatment experiences. Her second treatment program was an alternative to prison for felony prescription fraud and other misdemeanor charges. Robin left treatment against medical advice just short of completing that program.

Robin attends Day Treatment from 8 A.M. to 5:00 P.M. five days a week, and submits to random drug tests 4-6 times per week. She has done so since February 2003. During her breaks from treatment, she attends counseling, parenting classes and other personal appointments. Robin acknowledges that she is an addict and an alcoholic. She is beginning to recognize that this means she will struggle with addiction her entire life. Robin is working through her issues of grief and identity while trying to maintain a positive outlook on what the future holds. At present she is successfully parenting her two youngest children and making progress toward reuniting with her older three children sometime next year.

Unfortunately, Robin's case is far from unique. In 2003, Montana's Child and Family Services Division investigated 9,700 reports of child abuse and neglect. Roughly 40 percent of those families identified methamphetamine as either their primary or secondary drug of choice. That percentage jumped closer to 50 percent in 2004.

Child and Family Services will continue to collaborate with the Governor, Attorney General and with other law enforcement, public health and safety officials to achieve our division's mission, *Keep Children Safe and Families Strong*. Like all Montanans, we care about protecting vulnerable children from unsafe environments. They are, after all, our responsibility and our future.

EPSDT: Well Child Health

Medical check ups and more!

Prevention is key to a healthy childhood. Montana's Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is a preventive or well-child program for Medicaid-eligible children between the ages of birth and 20. There is no cost to parents, who are encouraged to take their children in for regular check ups. If the provider finds a problem with a child's physical or mental health, vision, or teeth during the exam, s/he is referred for further exams and treatment.

Well child check ups include a head-to-toe unclothed exam, vision, hearing, dental, speech and language checks, immunizations, lab tests, including blood lead levels, and health education. Transportation is available as needed.

Questions? Contact Anastasia Burton, Communications Manager, Medicaid Managed Care at 406-444-9538 or aburton@state.mt.us.

Not in Our Back Yard

by Ron Kemp

We want the word to spread through the drug world – if you want to do or sell drugs, don't go to northeastern Montana. —Ron Kemp, Field Agent for Big Muddy River Drug Task Force

Children are often found in homes where methamphetamine and other illegal substances are produced. Drug Endangered Children (DEC) programs are springing up around the country to coordinate the efforts of law enforcement, medical services and child welfare workers in support of these children.

The Big Muddy River Drug Task Force (BMRDTF) of Northeastern Montana is addressing local drug issues by using a DEC philosophy, through the combined efforts of tribal and county law enforcement officers, the FBI, social service agencies, medical professionals and other partners.

What happens when this well-oiled machine kicks into gear was demonstrated recently in a small town in Sheridan County. The first call from the local sheriff came in at 10 A.M., when he reported discovery of a meth lab. By 11:30, the task force was ready to pounce—search warrants, raid team and plan in place.

Five children, ages 5-12, were on the scene when officers reached the lab. As soon as the task force hit the door, an officer was calling for back-up services, including child protection workers, decontamination and medical screening personnel. Social workers were on scene before the officers got outside again. Their priority? Getting in safely, seeing that no one was hurt, and getting the kids out and into the hands of the appropriate authorities.

Whenever kids are present during a bust in the BMRDTF jurisdiction, each adult receives one count of child endangerment for every child present. If children test positive for drugs, distribution charges are added. If children have been used to facilitate drug transactions, charges for use of juveniles or use of juveniles within 1,000 feet of a school or public housing project are added, which can increase the penalties fourfold. *Everyone* is held accountable and the message is clear: don't involve or expose kids.

The BMRDTF started in 1996 after applying to the Montana Board of Crime Control as a multi-jurisdictional agency. Between 1997 and 2003, two large-scale investigations took place simultaneously, both of which involved the FBI. Operation *Rio Lobo* lasted from 1998-2000, and was ultimately named the most successful federal drug investigation on a reservation of its time. Operation *Dry Prairie* lasted from 1997-2003. These investigations shared complicated connections, much like the roots of a tree. In this case, those roots wound their way through five states and multiple jurisdictions.

Early on, the team patched a wireless video system together with bits and pieces of equipment, which worked well enough to bring dozens of defendants to justice. Afterward, the Fort Peck Tribes provided the task force with a "Cadillac of a video system," and a state-of-the-art surveillance vehicle. This equipment has helped ensure the success of many other operations.

Big Muddy River Drug Task Force team members include sheriffs' offices from Sheridan, Daniels, Richland, Roosevelt and Valley counties, the Fort Peck Tribal police and criminal investigation departments, and the Plentywood, Sidney, Fairview, Wolf Point, Poplar and Glasgow police departments. One full-time employee and one quarter time secretary support the task force, which covers a five-county region and the Fort Peck Reservation. Each member agency contributes equally to the match. Because coming up with the 25 percent match is difficult, the BMRDTF receives the smallest amount of funding of any task force in the state. The task force makes no bones about the fact that what they don't have in money, they make up in cooperation . . . that counties, cities, tribal and federal agencies have come together in a multi-jurisdictional team that is making progress toward the day when the "word" among criminals is "steer clear of northeastern Montana."

—After retiring as Chief of Police in Wolf Point, Montana, Ron Kemp became the Criminal Investigator for Roosevelt County Attorney's Office and the Field Agent Supervisor for the Big Muddy River Drug Task Force.

PNA Data Bites

The State of Montana Prevention Needs Assessment (PNA) has been conducted statewide every other year since 1998. The survey assesses adolescent substance use, anti-social behavior and the risk and protective factors that can predict adolescent problem behaviors.

18,577 students in grades 8, 10 and 12 were surveyed in Spring 2004. When comparing 2000 data to the 2004 data:

- *The percentage of students who used alcohol in the past 30 days has declined at every grade level.*
- *The percentage of students who used tobacco in the past 30 days has declined at every grade level.*
- *The percentage of students who used stimulants in the past 30 days declined at all 3 levels, with students reporting stimulant use at rates of less than 1 percent in grade 8, less than 2 percent in grade 10 and just over 3 percent in grade 12 (2004 PNA).*

For more information, contact Jackie Jandt, Coordinator of the Prevention Needs Assessment Project at jjandt@state.mt.us *or 406-444-9656.*

Statewide Efforts: *Drug Endangered Children*

by Agent Steve Spanogle

Although Montana is experiencing severe problems associated with the manufacture and abuse of methamphetamine, we have only seen the tip of the iceberg as compared to the devastation experienced by many other states. Efforts are taking place throughout Montana to begin dealing with the devastating effects of this deadly drug.

Montana's problem with the manufacture of methamphetamine became noticeable around the late 1990s. In the past, methamphetamine and the manufacture of methamphetamine were largely addressed by law enforcement, prosecutors and licensed addictions counselors. Until recently, law enforcement personnel did not have the training necessary to deal effectively with children found in an environment containing a meth lab. Oftentimes, the child would be put in the custody of a family member without the benefit of medical, mental health or other evaluations.

Studies conducted by the National Jewish Hospital show that during the manufacture of methamphetamine, the levels of methamphetamine, phosphine gas, acid gas and other fumes surpass expectations. Law enforcement personnel wear chemical suits with self-contained breathing apparatuses when they dismantle the labs—and new studies show that even this protective gear is not protective enough. All contents of the residence or vehicle where a lab is located are considered contaminated. This means that children's clothing, toys and other possessions are no longer usable.

Collaborative efforts are underway and many agencies are changing their policies for dealing with these children. Drug task forces throughout the state have purchased trailers or vehicles outfitted with the equipment necessary to decontaminate children.

When law enforcement rescues a child from a meth lab environment, the child is cleansed of any gross contaminants, then placed in a protective suit. The Department of Health and Human Services is notified immediately, and medical personnel are brought on scene to evaluate the child. Afterward, the child is handed over to a Department of Health and Human Services employee and transported to a local hospital for a complete medical evaluation. Meanwhile, law enforcement personnel conduct an investigation and collect evidence of the manufacture of dangerous drugs and criminal endangerment.

After the medical evaluation, a safe, appropriate placement is found for the child, who might also undergo a mental health examination to determine the effects of living in a environment where the drug is manufactured and/or abused. Laws pertaining to children located in houses that manufacturing drugs are continually being revised to assist in prosecution.

Many community and organizational efforts are also taking place. One such organization is the Montana chapter of the Prevention of Child Abuse. The Montana Council for Families is working on the Washington Foundation Project, which acquires clothing, toys and other items to replace those lost when children are removed from the lab.

Montana is learning from other states' efforts to protect children found in environments containing meth labs, and they are now being tested when removed. These tests reveal that 100 percent of these children have methamphetamine, and in some cases other chemicals, in their systems.

On November 16-17, the Montana Narcotics Officers Association (MNOA) and the Division of Criminal Investigation sponsored a statewide Drug Endangered Children Conference in Helena. The conference was hosted by the National Alliance for Drug Endangered Children and took a multi-disciplinary approach in addressing law enforcement officers, prosecutors, social workers, medical and mental health professionals. For more information, visit *www.MNOA.org*.

Child Abuse & Neglect

RISK factors: *child abuse and neglect occur in all segments of our society, but the risk factors are greater in families where parents:*

- *—seem to be having economic, housing or personal problems*
- *—are isolated from their family or community*
- *—have difficulty controlling anger or stress*
- *—are dealing with physical or mental health issues*
- *—abuse alcohol or drugs*
- *—appear uninterested in the care, nourishment or safety of their children*

WARNING signs: *The behavior of children may signal abuse or neglect long before any change in physical appearance. Some of the signs may include:*

- *—Nervousness around adults*
- *—Aggression toward adults or other children*
- *—Inability to stay awake or to concentrate for extended periods*
- *—Sudden, dramatic changes in personality or activities*
- *—Unnatural interest in sex*
- *—Frequent or unexplained bruises or injuries*
- *—Low self-esteem*
- *—Poor hygiene*

Source: www.preventchildabuse.org

Preventing Meth Use Through Innovative Partnerships

by Donna DeRosier

I don't think we can overestimate the impact of methamphetamine on Montana. The biggest tragedy is what happens to children. —Gail Gray, Director of the Montana Department of Public Health and Human Services

By some reports, methamphetamine (meth) is creating a statewide epidemic of substance abuse and associated social problems in Montana. Although felony methamphetamine cases and arrests are prevalent, the problem is not under control. The harmful effects are unchecked throughout this state. Given already overburdened systems, law enforcement agencies alone cannot deal with the situation. Recognizing the need for a new approach, Attorney General Mike McGrath has taken a comprehensive, statewide community effort to combat the problem. In June 2003, Attorney General Mike McGrath requested a meeting with representatives of the Montana Sheriffs and Peace Officers Association and Big Brothers Big Sisters (BBBS) of Montana in order to discuss the connection between the prevention efforts of BBBS and the work of law enforcement.

The mission of Big Brothers Big Sisters is to provide youth with the positive mentoring relationships that will help them become productive, self-reliant adults. Most of the children served by BBBS are considered "at-risk" youth: at increased risk of becoming involved in problem behaviors, such as drugs and delinquency, due to social, environmental and individual factors. Primarily a prevention program, BBBS meets the needs of such youth by providing a Big Brother or Big Sister. The relationship between the youth and the volunteer enhances the quality of the youth's life and enables that youth to reach his/her full potential.

Public/Private Ventures established that Little Brothers or Sisters who meet regularly with their "Bigs" are:

— 46% less likely to begin using illegal drugs;

— 27% less likely to begin using alcohol;

— 52% less likely to skip school; and

— 33% less likely to have violent confrontations.

The Center for the Study and Prevention of Violence selected Big Brothers Big Sisters as a *Blueprints for Prevention* Model Program (one of 11 selected from 600 programs reviewed). Selected programs met three criteria: evidence of deterrent effect, sustained effect, and multiple site replication. Programs also demonstrated good evidence of their effectiveness in delinquency, violence or substance abuse prevention and reduction.

The ability of BBBS to reduce the likelihood of problem behaviors is the link to law enforcement. To further the connection, Attorney General Mike McGrath facilitated the partnership between the Department of Justice, Montana Sheriffs and Peace Officers Association (MSPOA), and Big Brothers Big Sisters of Montana. The goal is to serve more at-risk children throughout Montana. To accomplish this, Big Brothers Big Sisters will receive help from the MSPOA in recruiting more law enforcement officers as volunteers, to develop a referral system for at-risk youth and to implement training for parents, volunteers and children to increase their knowledge of current issues facing Montana youth.

In support of this partnership, the Justice Department awarded Big Brothers Big Sisters $108,983 from its $2 million federal Community Oriented Policing Services grant. This provided the means to hire a coordinator to organize statewide mentoring efforts. The BBBS/MSPOA partnership is still in the developmental stages, but at this point all nine BBBS agencies in Montana are working with local sheriffs to craft partnerships specific to the needs of their communities.

For more information, contact Donna DeRosier at 1-888-412-BIGS (2447), 406-442-1982 or bbbsmontana@qwest.net.

—Donna DeRosier is the Chief Development Officer for Big Brothers Big Sisters of Montana.

*BBBS of Montana is an affiliate of Big Brothers Big Sisters of America, a best practice organization. This year, BBBS of America is celebrating 100 years of providing L*ittle Moments, Big Magic *for children through positive mentoring relationships. BBBS of Montana has served over 20,000 youth during the past 30 years.*

Big Brothers Big Sisters of Montana is a collaborative partnership among nine agencies, which are located in Billings, Bozeman, Butte, Great Falls, Helena, Kalispell, Livingston, Missoula, and Polson. The alliance encompasses service delivery areas in 17 counties and covers 72 percent of the Montana's population. For more information, visit BBBS Montana online at: *www.bbbsmontana.org.*

Parents' Concerns: *Kids With Disabilities*

by Dennis Moore

In 2003 PLUK had 10,200 contacts relating to kids with disabilities and their special health care needs.

As Executive Director of Parents, Let's Unite for Kids (PLUK), I've had the opportunity to talk with thousands of parents across the state of Montana, most of whom are parenting kids with disabilities.

Parents, Let's Unite for Kids (PLUK) is 20-year old nonprofit organization that covers the entire state. The primary office is in Billings, but employees work in all regions and live in most of the larger towns in the state. We also have 12 Associate Boards made up of volunteers who provide a regional voice and assist with recruiting volunteers, enhancing public awareness and helping the program grow. PLUK works with people who have all kinds of disabilities from the simplest learning disability to the most complex physical problems. The organization provides direction, clarification of what the disability means and of what the future may hold. Parents are offered information and resources to access what's needed and the training to develop the knowledge and skills to help them know what to do, where to turn and how to work with schools and agencies. The following observations reflect some of parents' most pressing concerns.

Parents are anxious that their child may not receive the educational services needed. This is an extremely complex issue and at PLUK we do everything we can to help parents understand the Special Education system and safeguards provided by the Individuals with Disabilities Act (IDEA). At the same time we work closely with schools and parents to help explore options and solutions. We also work with parents to help them learn how to interface with schools and how to better communicate their concerns and needs. Sometimes a disagreement between a parent and a school simply amounts to a misunderstanding or an inability to communicate effectively. It's my opinion that by and large most schools in Montana do an excellent job of providing services for kids with disabilities. It's also my opinion that we all need to work harder and more collaboratively in seeking solutions.

Parents are distressed with a lack of planning for the future and for the transition from public school to adulthood. Facilitating effective transition is not easy. To do it right requires time and hard work, and working together in support of specific goals to assist the child in preparing for the future. Good transitions also require parents' active participation. It's difficult, but done right, it is highly profitable for the child. Thankfully, many schools, agencies and parents are working together to make it happen and the process of transition seems to be improving every year.

Parents are frustrated with the lack of cooperation and collaboration among schools, agencies and professionals. This concern is not as prevalent as the first two, but parents often express it, though sometimes the *lack of a spirit of cooperation* may be fostered by the parents themselves. PLUK works hard to help parents learn how to communicate with schools, agencies and professionals. The child's best interest is the paramount concern and we need to find ways to bring parents to the table as equal partners.

My personal observation is that all of us need to become better at celebrating diversity because every one of us has something to offer. Everyone, including those with disabilities, must be accepted and their differences celebrated rather than being in disfavor or discouraged. Let's appreciate what others have to offer and how they can help, and maybe then our world will truly be a place of peace. These are the concerns of parents with kids with disabilities, as I too have a child with a disability . . . the same as the thousands I've talked with in the last several years.

—Dennis Moore is the Executive Director of Parents, Let's Unite for Kids. The observations he shares in the article are based largely on comments from and conversations with the parents of kids with disabilities.

Facts & Figures

- *There are approximately 19,000 students in Special Education in Montana schools.*
- *There are 55 separate categories of disabilities. (Based on the categories listed in contacts with Parents, Let's Unite for Kids.)*
- *Many more children have disabilities other than those that qualify for special education services in schools. Some authorities estimate that as many as 40% of the children in today's world have some form of a disability. Many learning disabilities go undetected.*
- *Some authorities estimate that as many as 80% of the inmates in prisons have disabilities.*
- *Autism and Aspergers Syndrome are two of the fastest growing disabilities (with respect to diagnosis) in the nation.*

The Children, Families and Human Services Interim Committee: *Findings and Recommendations*

by Susan Byorth Fox

The legislative Children, Families, Health, and Human Services Interim Committee recently completed its work on SJR11—a study of the problems attending alcohol and drug abuse, as well as of solutions based in prevention, early intervention and treatment. This study continued the work of the Alcohol, Tobacco, and Other Drug Control Policy Task Force. After reviewing the recommendations made by the task force and the accomplishments of the 2003 Legislature, the Committee prioritized *Coordinated Statewide Leadership* as its major issue. The Committee worked to find ways in which existing funding sources, programs and committees might be used to concentrate on substance abuse prevention and treatment, and finally completed its work through the finalization of two draft bills.

The major recommendation made by the Committee is the creation of a new *Office of Substance Use Prevention and Treatment* headed by a cabinet-level Commissioner appointed by the Governor. This office would replace the ICC and address the lack of coordination at the state level. Montana has numerous substance abuse prevention and treatment programs that are primarily funded by federal dollars. The State also funds treatment programs through the correctional system using general fund dollars.

This proposal reflects the effort to coordinate programs at the highest administrative level in a single office charged with the responsibility and the authority to concentrate on the big picture. It would review programs for duplication, recommend efficiencies and provide a single repository of statewide information. Ultimately, bridging substance abuse prevention and treatment efforts should result in more effective programs. There is no intent to take over or supplant existing programs, but only to coordinate and maximize the existing efforts.

The Committee purposely chose the front-end of the continuum—prevention and treatment—and left drug control and enforcement to the Attorney General, the Department of Justice and existing law enforcement efforts. The Committee did, however, elect to provide a link in the continuum through the Board of Crime Control, which administers a number of prevention funds. The Commissioner will be a statutory member of the Board of Crime Control, bringing perspectives from the Attorney General, law enforcement, juvenile justice and corrections.

The second draft bill is a resolution in support of current activities by the DPHHS, the Department of Corrections and the Board of Crime Control. Director Gail Gray responded with a proposal to create an intra-agency prevention coordinator, which dovetails with a pledge of continued support for the Prevention Resource Center, the PRC VISTA Program and the *Prevention Connection* newsletter. The resolution encourages the next administration to continue support of these efforts.

If this proposal is to succeed, it will require political will, agency cooperation, leadership and public support. These cannot be legislated. This solution means that someone will be focusing on the "big picture" in the areas of substance abuse prevention and treatment. Without exception, existing programs have full plates, plenty of responsibilities and a tight budget. The intent of this proposal is to bring a statewide strategic plan to the substance abuse prevention and treatment arena—and ultimately to assist communities in saving the human and societal costs of the failure to do so.

—Susan Byorth Fox is a Legislative Research Analyst, and staffed the Children, Families, Health, and Human Services Interim Committee.

Welcome

Marlene Disburg has been named Prevention Program Coordinator for the Office of Planning, Coordination and Analysis in the Montana Department of Public Health and Human Services (DPHHS). She will serve as an adviser and technical resource to state agencies and other organizations in building a comprehensive statewide system of health-related prevention programs with common visions and missions.

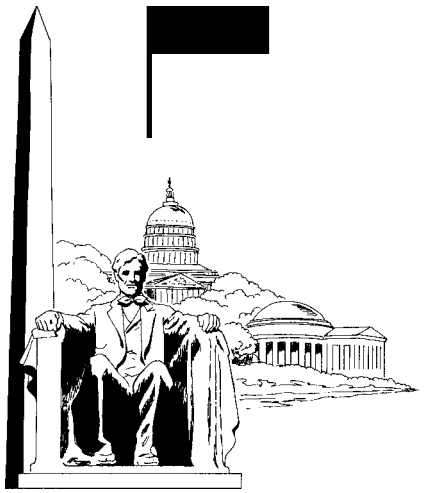
Disburg has worked for DPHHS since 1999, most recently as a regional planning officer for the Addictive and Mental Disorders Division. She received a degree in human services with an emphasis on community development from Black Hills State University in South Dakota and has spent most of her career working with people with disabilities.

The ICC's Unified Prevention Budget shows that the substance abuse prevention budget was approximately $4.75 million in FY04, yet only $2 million rested with the Department of Public Health and Human Services (DPHHS) Addictive and Mental Disorders Division. DPHHS divisions house a tobacco use prevention program and a fetal alcohol syndrome program, and other state agencies administer enforcement of underage drinking laws, safe and drug free schools programs, and Title V juvenile delinquency prevention funds. There are also programs in other state departments that relate to prevention and treatment of substance abuse.

The D.C. Connection

Creating a Safe Environment for Children

by Theresa Racicot



Adolescence! It's a critical developmental phase, an important launching pad to the future for most children—a collision course for others. It's filled with excitement, self-doubt and the fear of not fitting in.

Juxtapose that reality with what kids see every day in the media—parties, good times, extreme behavior, sports . . . and drinking alcohol. Constant media messaging helps kids form opinions. Since most parents aren't around 24/7, advertisers know their messages will find a receptive audience and make a strong impression.

We don't even have to look to the ads to see where children first encounter the sense that drinking is a part of every activity. Look at the number of children's movies where alcohol is part of the defining moment for the hero, from Elliott kissing his classmate in *E.T.* to Dumbo figuring out he can use his ears to fly after falling into a vat filled with alcohol.

Public health research has found that youth exposure to alcohol advertising increases awareness of that advertising (Collins, et al, 2003), which in turn influences beliefs about drinking, intentions to drink and drinking behavior (Martin, et al, 2002). *Every day, 7,000 kids under age 16 take their first drink* (SAMHSA, 2004). With $6 billion spent on alcohol advertising and marketing each year, it isn't any wonder that so many kids think it's cool to drink—nor that nearly one-third of kids begin drinking alcohol before age 13 (Grunbaum, et al., 2002). In 2003, every one of the 15 television shows most popular with teens carried alcohol advertising, providing advertisers with a targeted opportunity to show over 2,600 alcohol ads (CAMY, 2004). You can be certain that those ads never showed the downside of alcohol use.

An overriding goal of prevention must be creating an environment that is friendly to adolescent development, allows youth to explore and take some risks, yet protects youth from putting themselves at risk of serious—often irreversible—consequences. Parents are the first line of defense. They must refuse to provide alcohol for their children's underage friends, set clear guidelines that alcohol use is unacceptable for anyone under age 21, and band together with other parents to make sure the message is unequivocal and enforced.

Underage drinking is a public health issue that has reached epidemic proportions. By way of contrast, another health issue involving children—childhood obesity—is being treated with great concern by elected officials. "Half-measures won't work. It has to be a comprehensive national response. It is a clarion call to Congress for us to act boldly." We need to expect *the same* gusto on the childhood drinking issue.

Research suggests that a variety of interventions can delay the onset of drinking behavior or reduce heavy problematic drinking among people younger than 21. The *most documented principle in alcohol use prevention is this*: make it harder for young people to get alcohol, and they will drink less. Communities can make alcohol less available by promoting responsible adult behavior and holding adults accountable when they provide alcohol to minors; by raising the price of beer, wine, and liquor; and/or by reducing the number of places where alcohol is sold or served.

Another way is to consistently enforce underage drinking policies. Studies find that existing laws regulating underage drinking are often not enforced. When these laws are ignored, it enables young people to drink and communicates a general indifference.

Finally, when communities consistently prevent underage access to alcohol, publicize and enforce alcohol-related laws, and limit the promotion of alcohol, they reinforce the message that alcohol use by young people is unacceptable. Clearly, the more effective programs utilize comprehensive, environmental approaches that include individuals, families, elected officials, teachers, law enforcement, the business sector, faith-based organizations, and the media.

When planning a prevention campaign, it is important to consider what will work best for your community. Approaches need to be:

- *—direct, so people will understand what is being proposed;*
- *—possible within the resources, constraints, and influence of your community or agency;*
- *—generally supported by citizens, businesses, and public officials;*
- *—able to show some results in the short term; and*
- *—help build coalitions or partnerships that will expand the reach of the campaign.*

For further information about prevention approaches that work, as well as specific examples of what real communities are doing, go to: www.alcoholfreechildren.org.

The Last Word

by Joan Cassidy

This issue of the *Prevention Connection* tackles the difficult issue of children and youth dealing with situations that somehow fall outside the norm. We would like to think that dealing with chemical dependency issues is outside the norm for our culture, but it is not.

My job, as Chemical Dependency Bureau (CDB) Chief, is to oversee the state's publicly funded substance abuse and prevention delivery system. I came to this job with a vision of streamlining the current system and building in efficiencies, eliminating duplication of services and maximizing strengths.

For the past several months, the CDB has been seriously understaffed. This has been difficult, and yet it has offered the perfect opportunity to consider how we could use existing vacancies to accomplish our goals. This meant redefining and rearranging positions. The new structure is built on a continuum of care model that is both visionary and accountable. The first step toward building this structure is already underway and will mean adding two new supervisory positions to oversee the day-to-day operations of the bureau.

Program Planning & Outcome Officer: This position will serve as the CDB's visionary. S/he will guide planning efforts for the Substance Abuse Prevention & Treatment (SAPT) Block Grant, facilitate the county planning process and oversee the biannual Prevention Needs Assessment. This position will be charged with ensuring that all administrative and Medicaid rules and reporting requirements are met. This position will supervise the Training Officer and the Program Monitoring and Data Outcome Officer.

Program Administration Officer: This position will ensure the use of best practices based on sound clinical research and outcome studies throughout the publicly funding chemical dependency system. S/he will implement best practices or evidence-based programming, and serve as a clinical expert. This position will also supervise both program officers, whose responsibility it is to oversee program contracts and compliance.

One of the most obvious efficiencies that will come with this reorganization is that each provider will be assigned a single program officer. In years past, a provider might work with two or more program officers or administrators, each of whom was charged with overseeing a discrete part of the continuum. Assigning a single officer who will work on prevention, treatment *and* intervention will reduce the potential for duplication and for confusion. Because of the single voice and potential for long-term relationships, this system will also help us build, maintain and strengthen partnerships with providers, communities and other agencies. Ultimately this means better and more efficient service for our providers, and ultimately, for their clients through a comprehensive continuum of services that include treatment, intervention and prevention. That is my goal.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

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